Cancer Care Ontario

Your Symptoms Matter – Prostate Cancer

For patients not being seen at RVH, please fax results to 705-739-5619.

Patient Name: _____ Health Card Number: _____

Date of Birth: _____ Physician: _____ Date of Visit: _____

Patients: Please answer the following questions by circling the appropriate answer. All questions are about your health and symptoms in the **LAST FOUR WEEKS.**

Select ONE answer for each question.

1. Overall, how much of a problem has your urinary function been for you? Leave the question blank if you have a catheter.

0 – No problem	1 – Very small problem	2 - Small problem	3 – Moderate problem	4 – Big problem

2. Which of the following best describes your urinary control? Leave the question blank if you have a catheter.

0 – Total control	1 – Occasional dribbling	2 – Frequent dribbling	4 – No Urinary control

3. How many pads or adult diapers per day have you been using for urinary leakage? Leave the question blank if you have a catheter.

0 - None	1 – One pad per day	2 – Two pads per day	4 – Three or more pads per day

4. How big a problem, if any, has urinary dripping or leakage been for you? Leave the question blank if you have a catheter.

0 - No problem	1 - Very small problem	2 – Small problem	3 – Moderate problem	4 – Big problem

How big a problem, if any, has each of the following been for you? Leave the question blank if you have a catheter.

	No problem	Very small problem	Small problem	Moderate problem	Big problem
5. Pain or burning with urination	0	1	2	3	4
6. Weak urine stream/incomplete bladder emptying	0	1	2	3	4
7. Need to urinate frequently	0	1	2	3	4

Please turn to the next page for more questions.

How big a problem, if any, has each of the following been for you?

	No problem	Very small problem	Small problem	Moderate problem	Big problem
8. Rectal pain or urgency of bowel movements	0	1	2	3	4
9. Increased frequency of your bowel movements	0	1	2	3	4
10. Overall problems with your bowel movements	0	1	2	3	4
11. Bloody stools	0	1	2	3	4

12. How would you rate your ability to reach orgasm (climax)?
Answer based on your best possible functioning with or without medication.

0 – Very good	1 – Good	2 – Fair	3 – Poor	4 – Very poor to none

13. How would you describe the usual quality of your erections?
Answer based on your best possible functioning with or without medication.

0 – Firm enough for intercourse	1 – Firm enough for masturbation and foreplay only	2 – Not firm enough for any sexual activity	4 - None at all

14. Overall, how much of a problem has your sexual function or lack of sexual function been for you?
Answer based on your best possible functioning with or without medication.

0 - No problem	1 - Very small problem	2 - Small problem	3 – Moderate problem	4 – Big problem

How big a problem, if any, has each of the following been for you?

	No problem	Very small problem	Small problem	Moderate problem	Big problem
15. Hot flashes or breast tenderness/enlargement	0	1	2	3	4
16. Feeling depressed	0	1	2	3	4
17. Lack of energy	0	1	2	3	4

Activities and Function: over the past month I would generally rate my activity as:

- ☐ 0 – Normal with no limitations
- ☐ 1 – Not my normal self, but able to be up and about with fairly normal activities
- ☐ 2 – Not feeling up to most things, but in bed or chair less than half the day
- ☐ 3 – Able to do little activity & spend most of the day in a bed or chair
- ☐ 4 – Pretty much bedridden, rarely out of bed